ALOQUIN GEL PA SUMMARY

STATUS: Non-Preferred

LENGTH OF AUTHORIZATION: 1 Year

PA CRITERIA:

- Approvable for members 12 years or older

AND

- Submit documentation of trial and failure of at least one preferred formulary alternative (antibacterial or antifungal agent) appropriate for the diagnosis (Bactroban cream, econazole cream, gentamicin cream/ointment, ketoconazole cream, mupirocin ointment, nystatin cream/ointment).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827.**

PA and APPEAL PROCESS:

- For online access to the PA process please go to www.ghp.georgia.gov, select the Provider Information tab, click on "view full text" in the Pharmacy Services box, click on "Prior Approval Process" in the list on the left.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limit please go to www.ghp.georgia.gov, select Provider Information, click on "view full list" in the Medicaid Provider Manuals box then select Pharmacy Services from the list shown.